## NOTICE TO NURSES REGARDING ACT 198

**Act 198 (effective July 1, 2003) establishes a Center for Nursing (Center) at the University of Hawaii School of Nursing and Dental Hygiene. The Center will help to ensure that better data about nurses is available, which will improve health care in Hawaii, as well as working conditions for nurses. The Center will collect and analyze data and prepare and disseminate written reports and recommendations regarding the current and future status and trends of the nursing workforce. The Center will conduct research on best practices and quality outcomes, as well as develop a plan for implementing strategies to recruit and retain nurses. Act 198 establishes a special fund to support the Center's activities and requires the assessment of a $40 fee upon the issuance of a new nurse license and at each license renewal. Beginning on July 1, 2003, each new license will be assessed the $40 fee to support the Center, and beginning with the 2005 renewal, the fee will be assessed for each license renewal.**

## REQUIREMENTS FOR RECOGNITION - ADVANCED PRACTICE REGISTERED NURSES APPLYING FOR RECOGNITION IN THE STATE OF HAWAII

Access this form via website at: **www.hawaii.gov/dcca/pvl**

*(This is not an application for **Prescriptive Rights**)*

## INSTRUCTIONS FOR FILING

**APPLICANTS FOR APRN RECOGNITION**

REGISTERED NURSES WHO HOLD A CURRENT, UNENCUMBERED LICENSE IN THE STATE OF HAWAII, may apply for initial recognition by submitting the following:

1. An official transcript of the **master's degree in nursing** from an accredited or approved school must be sent **DIRECTLY** to the Board from your nursing school; **OR**

2. Verification of current certification in the nursing specialty sent **DIRECTLY** to the Board from the national certifying body recognized by the Hawaii Board of Nursing. Please contact your organization and have them send verification of your current status. See list of recognized certifying bodies on attached application; **AND**

3. Verification of unencumbered license as a registered nurse **and** as an APRN or similar designation in all states in which you are **CURRENTLY** licensed. Use form *(NSG-28)*, if applicable. This form may be duplicated.

**APPLICATION FORM**

1. Type or print *legibly* in dark ink.
2. Answer **all questions. If not applicable, write N/A.**
3. Sign application.

- **Failure to provide all the requested information will delay the processing of your application.**

If you are applying for more than one category, be sure to have the appropriate documentation (Master's degree or current certification) sent **directly** to the Board for each category.
Incomplete applications will not be accepted and will be returned for completion. Failure to complete the licensing requirements within two (2) years, will void your application (436B-9, HRS).

**ADDRESS**

The Board's mailing address is:
*Hawaii Board of Nursing*
*P.O. Box 3469*
*Honolulu, HI 96801*
*Phone: (808) 586-3000*

OR

Deliver to office location:
*Hawaii Board of Nursing*
*335 Merchant St., Room 301*
*Honolulu, HI 96813*

**FEES**

Make check payable to: *COMMERCE AND CONSUMER AFFAIRS*

| | Fee |
|---|---|
| If license will be issued between JULY 1, ODD-NUMBERED years (2003, 2005) and JUNE 30, EVEN-NUMBERED years (2004, 2006), pay (Application - $40**, License - $20, Compliance Resolution Fund –$70***, ½ renewal – $10, Center for Nurse Fee – $40 – see attached notice) | $180 |
| *If license will be issued between JULY 1, EVEN-NUMBERED years (2004, 2006) and JUNE 30, ODD-NUMBERED years (2003, 2005), pay (Application - $40**, License - $20, Compliance Resolution Fund - $35***, Center for Nurse Fee – $40 – see attached notice) | $135 |

- If you are eligible for a license near the end of the second year of a two-year license period (within 3 months), you may elect to delay the issuance of your license until July 1, odd-numbered year, **provided you do not intend to start practicing your trade or profession until the next license period.**

**Note:** *One of the legal requirements that you must meet in order for your new license to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a $15.00 service fee will be charged for checks which are returned by the bank.*

*If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.*

** **If you select this option, your license will be subject to renewal by June 30, 0dd numbered year – REGARDLESS of issue date.***
*** Application fee is not refundable.*
****The Compliance Resolution Fund (CRF) was established by the 1982 Legislature (§26-9(m), HRS, to expedite resolution of consumer complaints filed with the Department of Commerce and Consumer Affairs. Assessment amounts are based on the services rendered in resolving complaints. Assessment is due for the issuance of a new license as well as for the renewal of a license.*



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**ADDITIONAL CATEGORY**

Once you are licensed as an Advanced Practice Registered Nurse (APRN) and wish to apply for an additional category, you will need to complete another application for APRN and submit an application fee of $40.00. An official transcript of the master's degree in nursing **OR** verification of current certification in the nursing specialty must be sent **DIRECTLY** to the Board. You will not be required to submit verification of an unencumbered license again.

**ABANDONMENT OF APPLICATION**

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years; provided that the failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit the required documents and othe information requested by the licensing authority within two consecutive years from the last date the documents or other information were requested, or (2) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process, including attempting to complete the examination requirement.

**NOTIFICATION OF DISCIPLINARY ACTION**

Once recognized, the APRN is responsible for notifying the Hawaii Board of Nursing of any disciplinary action taken against any nursing license/APRN recognition in any other state or U.S. jurisdiction within 30 days of the action. Failure to do so may result in action against the nurse's Hawaii APRN recognition and nurse's license.

**STATE LAWS AND RULES**

All applicants/licensees are responsible for reading, being knowledgeable and maintaining current knowledge of the Hawaii Statutes and Rules relating to nursing and the amendments adopted throughout the years for the duration of the applicant/licensee's nursing career. Copies are available by submitting a written request to the Board.

a. Chapter 457, Hawaii Revised Statutes, Nurses.
b. Chapter 89, Hawaii Administrative Rules, Nurses.
c. Chapter 436B, Hawaii Revised Statutes, Professional & Vocational Licensing Act.

The laws and rules are also posted on our website at: www.hawaii.gov/dcca/pvl. Click on "Nursing".

**ADDRESS/NAME CHANGES**

It is the responsibility of the applicant to notify the Board of any changes **in writing.** If you have a name change **after** your application was originally filed, you must provide a photocopy of the name change document along with a letter requesting the change. All address changes must be submitted **in writing.** No changes will be accepted over the phone. The Board will not be responsible for non-receipt of any correspondence.

**LICENSE RENEWALS**

All nursing licenses and APRN Recognition, **regardless of issue date**, expire on June 30 of each odd-numbered year (2005, 2007) and are subject to renewal. Your Registered Nurse license and APRN Recognition both require a separate renewal form and fees. An APRN Recognition cannot be renewed unless the RN license is renewed.

a) APRNs who were recognized initially by their MSN degree shall submit:
   1) Renewal application; and
   2) Fees.
b) APRNs who were recognized initially by national certification shall submit:
   1) Renewal application;
   2) Fees; and
   3) Proof of current certification.

All certified nurse midwives shall meet the renewal requirements of (b).

AT NO TIME MAY A NURSE, WHOSE LICENSE HAS LAPSED, CONTINUE TO PRACTICE AS A NURSE. IT IS THE NURSE'S DUTY TO INFORM EACH EMPLOYER WHO IS IMPACTED, OF THE NURSE'S FAILURE TO RENEW A NURSING LICENSE ON TIME.

**ADVANCED PRACTICE REGISTERED NURSES WITH PRESCRIPTIVE AUTHORITY (APRN-Rx)**

Contact the Department of Commerce and Consumer Affairs at (808) 586-3000 for a separate application, or you may download the application from: www.hawaii.gov/dcca/pvl

Note: The requirements for APRN with prescriptive - Authority include both Master's Degree in Nursing and current national certification. Therefore, if you intend on filing for Prescriptive Authority in the near future, you may elect to request your school of nursing send two (2) transcripts to the Board and your national certifying organization send two (2) verifications of current status to the Board at one time.

# APPLICATION FOR APRN RECOGNITION

(This is not an application for prescriptive rights.)

*Read the attached instructions before completing this form. Print Legibly.*

| Legal Name (First, Middle) | (LAST) |
|---|---|
| | |

Other Names Used (include maiden name)

Residence Address (Include Apt. No., City, State and Zip Code) - REQUIRED

Mailing Address (**ONLY** if different from above)

| Social Security No. | Phone No. (days) |
|---|---|
| | Hawaii RN Lic # RN - |

OFFICE USE ONLY

[ ] Master's Degree transcript [ ] National Certification

| Date Eff. | Lic No.<br>APRN - |
|---|---|
| RN –<br>Exp date: 6/30/_____ | Category Code: |

- Give date you requested official MSN transcripts to be sent directly to the Board's office _____
- Give date you requested current certification to be sent directly to the Board _____
- List all states in which you are **CURRENTLY** licensed as a RN _____
  (Include date you requested verification to be sent directly to the Board)_____
- List all states in which you are **CURRENTLY** recognized as an APRN _____
  (Include date you requested verification to be sent directly to the Board) _____

Check APRN category and subcategory applying for:

____ **NURSE PRACTITIONER**

- _____ Adult NP
- _____ Gerontological NP
- _____ Pediatric NP
- _____ Acute Care NP
- _____ School NP
- _____ Neo-Natal NP
- _____ Women's Health Care NP
- _____ Family NP
- _____ Psychiatric Mental Health NP
- _____ Family Health NP
- _____ Community Mental Health NP
- _____ Other titles authorized by national APRN certifying bodies:_____

_____ **CLINICAL NURSE SPECIALIST**

- _____ Gerontological CNS
- _____ Medical-Surgical CNS
- _____ Community Health CNS
- _____ Adult Psychiatric & Mental Health CNS
- _____ Child & Adolescent Psychiatric & Adult Mental Health CNS
- _____ Maternal - Child CNS
- _____ Pain-Management CNS
- _____ Community Mental Health CNS
- _____ Critical Care CNS
- _____ Adult CNS
- _____ Family/Child CNS
- _____ Parent-Child CNS
- _____ Pediatric CNS
- _____ Oncology CNS
- _____ Other titles authorized by national APRN certifying bodies: _____

____ **NURSE ANESTHETISTS**

_____ **CERTIFIED NURSE MIDWIVES**

EDUCATION

| Name and Location (city/state) | Dates (mo/yr) From | Dates (mo/yr) To | Degree Earned |
|---|---|---|---|
| APRN SPECIALTY PROGRAM | | | |
| Nursing School where you received highest degree | | | |

| | | |
|---|---|---|
| App | 433 | $40 |
| Lic | 436 | $20 |
| CRF | 439 | $35/$70 |
| Center for Nurse Fee | CFN | $40 |
| 1/2 Ren | 430 | $10 |
| Service Fee | BCF | $15 |



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**APPLICATION FOR APRN RECOGNITION**

Are you currently certified by a National Certifying Organization? (circle one) ..... YES NO

_____ American Nurses Credentialing Center
_____ National Certification Board of Pediatric Nurse: Practitioners/Nurse
_____ National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties
_____ American College of Nurse-Midwives
_____ American Association of Nurse Anesthetists
_____ American Academy of Nurse Practitioners
_____ Council on Certification of Nurse Anesthetists
_____ Oncology Nursing Certification Corporation
_____ National Association of Pediatric Nurse Associates and Practitioners

ALL APPLICANTS

Circle answers and give details when required:

1) Are you at least 18 years of age? ..... YES NO

2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ..... YES NO

3) In the past twenty years, have you ever been convicted of a crime for which the conviction has not been annulled or expunged? ..... YES NO
*If "YES", arrange to have certified court documentation on the date, place, violation for each conviction And fulfillment of conditions of each sentence sent directly to the Board.*

4) Has your nursing license ever been revoked, suspended, or otherwise subject to disciplinary action by another state board? ..... YES NO
*If "YES", arrange to have certified documents from <u>each</u> state in which disciplinary action was taken sent directly to the Board. (Include Findings of Fact, Conclusion of Law, Recommended Order, Final Order, and whether you have been re-instated. If re-instated, date and conditions of license.)*

5) Are you presently being investigated or is any disciplinary action pending against you? ..... YES NO
*If "YES", specify all states where action was or may be imposed. Arrange to have certified documents from each state in which disciplinary action or investigation occurred or is pending against you sent directly to the Board.*

*Note: All applications may be subject to Board review. Additional information may be requested for the purpose of clarification.*

6) Do you hold or have you ever held an APRN Recognition license in Hawaii? ..... YES NO
*If "YES", give license number:* _____ *Expiration date:* _____

AFFIDAVIT OF APPLICANT:

I hereby certify that the information supplied herein and attachments thereto are true and correct. I understand this affidavit and that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, Hawaii Revised Statutes.)

_____ Date

_____ Signature of Applicant

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

State of Hawaii
Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

# VERIFICATION OF RN/APRN LICENSE - (Applicant Applying for APRN Recognition)

Access this form via website at: **www.hawaii.gov/dcca/pvl**

**APPLICANT**

*APPLICANT: Complete top of this page and forward to state of license. (NOT HAWAII)*

| Name (LAST) | FIRST, Middle | Other names used (include maiden name) |
|---|---|---|
| | | |

Address (Include Apt. No., City, State and Zip Code)

Phone No.

Social Security No.

LICENSE NUMBER DATE ISSUED

Type of Registration:

REGISTERED NURSE ADVANCED PRACTICE REGISTERED NURSE

I hereby authorize the nursing licensing agency in the State of _____ to furnish to the Department of Commerce and Consumer Affairs, State of Hawaii, the information below.

Date _____ SIGN HERE: _____

**LICENSING AGENCY ONLY**

This is to certify that the above-named individual was issued the following:

[ ] **REGISTERED NURSE LICENSE (complete only if active license is maintained)** Date of Issuance: _____

Licensed by: [ ] examination [ ] endorsement [ ] waiver

Current license status: [ ] Active [ ] Inactive [ ] Lapsed

**Has this license ever been encumbered in any way (revoked, suspended, limited, placed on probation?** [ ] yes [ ] no

(If yes, please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether license has been restored, reinstated, or new license issued)

Date license expires: _____

[ ] **ADVANCED PRACTICE REGISTERED NURSE (complete only if active license is maintained)** Date of Issuance: _____

**Has this license ever been encumbered in any way (revoked, suspended, limited, placed on probation?** [ ] yes [ ] no

(If yes, please submit certified documents relating to disciplinary action of this license including Findings of Fact, Conclusions of Law, Recommended Order, Final Order, and whether License has been restored, reinstated, or new license issued)

Date license expires: _____

*SEAL*

Signature _____

Title _____

State _____

Date _____

*TO THE BOARD: Return this form **directly** to the Hawaii Board of Nursing.*

State of Hawaii
Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

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Date license expires: _____

*SEAL*

Signature _____

Title _____

State _____

Date _____

*TO THE BOARD: Return this form **directly** to the Hawaii Board of Nursing.*